Appendix 1

Written Correspondence Inquiry Form

Please complete this side of the form.

Provider Name: _____ Provider #: _____

Contact Person: _____ Phone #: _____

Street Address: _____

City, State, ZIP: _____

Claim/Adjustment in Question *(Attach a copy of the claim or adjustment and Remittance and Status (R/S) Report page):*

Recipient Name: _____

Recipient Medicaid #: _____

Claim Number: _____

Date(s) of Service: _____

Amount Billed: $ _____ R/S Report Date: _____

Explanation of Benefits (EOB) Code(s): _____

Other: _____

Reason for Inquiry:

____ Questioning claim denial that Provider Services could not assist with (please explain below).

____ Provider Services or Professional Relations representative advised writing (please explain below).

____ Inquiry involves extensive documentation or research (please explain below).

____ Other (briefly explain the situation in question): _____

_____

_____

_____

_____

_____

Provider Signature _____ Date _____

Retain a copy of this inquiry for your records and submit it to:

Wisconsin Medicaid
Written Correspondence Unit
6406 Bridge Road
Madison, WI 53784-0005

Information Needed:
In order to complete research on your inquiry, the following information is needed. Please send the information to Written Correspondence, along with all materials originally sent to Written Correspondence.

____ Provider name and eight-digit Medicaid provider number.

____ Recipient name and 10-digit Medicaid number.

____ Copy of any previous response related to the inquiry.

____ Date of service.

____ Amount billed.

____ R/S Report (copy - not original).

____ Copy of the claim in question.

____ Copy of the Medicare Explanation of Medicare Benefits (EOMB).

____ Copy of the adjustment in question.

____ Record of treatment dates.

____ Other (briefly explain the situation in question): _____

_____

_____

_____

--This section will be completed by Written Correspondence staff. --

Resolution of Inquiry:

____ Claim/adjustment was resubmitted by Wisconsin Medicaid through normal processing channels.

____ Claim/adjustment was resubmitted by Wisconsin Medicaid with special instructions for processing.

____ Claim has been forwarded for consultant review.

____ Claim was denied correctly. Review _____ and call Provider Services if more information is needed.

____ Claim/adjustment was paid on your R/S Report dated _____ .

____ Claim/adjustment was denied on your R/S Report dated _____ .

____ Claim and documentation was forwarded to Late Billing Appeals for review.

____ Resubmit the claim/adjustment through normal processing channels.

____ This claim exceeds the 12-month filing deadline. Refer to the Claims Submission section of the All-Provider Handbook and resubmit with documentation to Late Billing Appeals ONLY if the claim meets one of the criteria indicated for submission to Late Billing Appeals.

____ Other: _____

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_____

WCN _____ Correspondent Signature _____ Date _____